Chapter 6

Inpatient Psychiatric Services and Residential Treatment Centers for Children and Adolescents

Inpatient Psychiatric Services And Residential Treatment Centers for Children and Adolescents: Overview and Definitions

Inpatient psychiatric care of children and adolescents addresses disabling symptoms including impaired sense of reality, disordered or bizarre behavior, psychosis, depression, anxiety, hysteria, phobias, compulsion, insomnia, and eating disorders. This excludes primary diagnoses of alcohol and drug abuse, mental retardation, and organic brain syndrome. The State Health Plan defines children as up to 11 years old, and adolescents as ages 12-17 years. The variability of individuals and their manifestation of psychiatric conditions may mean that some children may be treated in an adolescent unit, while some adolescents may be appropriately treated in either a child or adult unit. For most children and adolescents, quality of care is enhanced when they are treated in separate units, since they have different therapeutic needs from adults, require specialized educational and recreational programs, and tend to experience longer inpatient stays. Each distinct age group is best served in a discrete unit designed to meet its special needs.[1]

Under Maryland statute, "residential treatment center" ("RTC") means a "related institution," as defined in Health-General Article §19-301 *et seq.*, Annotated Code of Maryland and licensed under COMAR 10.07.04, that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbance or mental illness who require a self-contained therapeutic, educational, and recreational program in a residential setting whose length of stay averages between 12 and 18 months. RTCs typically also offer outpatient day treatment services and schooling for children and adolescents who are unable to live at home.[2] Residential treatment centers focus on maximizing a child or adolescent's development of appropriate living skills. An RTC is a very intense level of care and should only be provided when therapeutic services available in the community are insufficient to address the child or adolescent's needs. Discharge planning is considered prior to placement in an RTC, and plans are actively reviewed throughout the treatment process[3].

[1] State Health Plan, COMAR 10.24.07, Supp. 14, AP-2, Revised June 30, 1997.

[2] Ibid.

[3] Ibid.

Supply and Distribution of Inpatient Psychiatric Services and Residential Treatment Centers for Children and Adolescents

Inpatient child and adolescent psychiatric services are provided in acute general hospitals, private psychiatric hospitals, and State psychiatric hospitals. Over the last five years, two private psychiatric hospitals that provided inpatient psychiatric hospital care for children and adolescents have closed: Gundry-Glass Hospital in southwestern Baltimore City closed on October 14, 1997, and Chestnut Lodge in Rockville (Montgomery County) closed on April 27, 2001.[4]

There are 235 child and adolescent inpatient psychiatric beds licensed to operate in Maryland. As Table 6-1 shows, child and adolescent psychiatric beds may be found in all regions of the State, except for Southern Maryland.

[4] Sheppard Pratt Health Systems purchased the inpatient beds from both of these facilities. Sheppard Pratt has relinquished the 14 adolescent psychiatric beds remaining from the closed Gundry-Glass Hospital, and is presently in discussions with Montgomery County officials regarding the relocation of the 30 child and adolescent psychiatric beds from the now closed Chestnut Lodge to another site within Montgomery County.

Table 6-1
Child and Adolescent Psychiatric Hospital Facilities: Maryland, October 2001

Hospital	Jurisdiction	Beds*	Hospital Type
Finan Center	Allegany	18	State Psychiatric
Brook Lane Psychiatric Center	Washington	28	Private Psychiatric
Carroll County General	Carroll	12	Acute General
Sheppard Pratt	Baltimore	56	Private Psychiatric
Franklin Square	Baltimore	6**	Acute General
Johns Hopkins	Baltimore City	15	Acute General
University of Maryland	Baltimore City	12	Acute General
Taylor Manor	Howard	20	Private Psychiatric
Potomac Ridge	Montgomery	25	Private Psychiatric
Laurel Regional	Prince George's	5	Acute General
Dorchester General	Dorchester	5	Acute General
Chesapeake Hospital	Dorchester	15	Private Psychiatric
Total		**217**	

* Includes all licensed beds, regardless of whether currently staffed and operating.
**This figure modifies bed capacity information presented in Chapter 5, which shows Franklin Square Hospital Center as having 24 adult beds, and no child or adolescent beds. The hospital had not indicated on its annual licensure form that 6 of its psychiatry beds had been approved to be designated as child beds.

Source: Maryland Health Care Commission files and Office of Health Care Quality Licensure Reports, October 2001

In addition, seven acute general hospitals, listed at Table 6-2, treat a significant number of adolescents in their adult psychiatric units, but have not identified on their license any of their general hospital beds as serving an adolescent population. These hospitals treated 689 adolescents in calendar year 2000. The reasons for these increased admissions include a growing number of referrals from area emergency rooms and Department of Juvenile Justice facilities, closure of private psychiatric hospitals and day treatment programs, and, anecdotally, increasingly restrictive utilization decisions by Maryland Health Partners[5] in approving outpatient rehabilitation and other services for the "gray area" population.[6]

[5] Maryland Health Partners, a subsidiary of Magellan Behavioral Health, is the Administrative Service Organization ("ASO") that holds the contract to administer Maryland's public mental health system for its Medicaid and gray area populations.

[6] The "gray area" population is defined as earning up to 300% of the Consumer Poverty Index ("CPI"). Services to this population will be reduced in the up-coming fiscal year due to the existing and projected budget deficit for the Maryland Mental Hygiene Administration and the mental health "carve-out".

Table 6-2
Acute General Hospitals Providing Adolescent Psychiatric Care in Adult Psychiatric Beds: Maryland, Calendar Year 2000

Facility Name	Jurisdiction	CY 2000 Child/Adol Discharges[7]	CY 2000 Adult Discharges	Pct. Child/Adol.	Licensed Adult Beds
Calvert Memorial	Calvert[8]	110	355	23.66	13
Suburban	Montgomery[9]	77	789	8.89	24
Montgomery General	Montgomery[10]	91	991	8.41	27
Washington Adventist	Montgomery	113	1453	7.22	40
Southern Maryland	Prince George's[11]	105	811	11.46	25
St. Joseph's	Baltimore	94	483	16.29	34
Howard Co. General	Howard	99	466	17.52	14
Total		689	5348	11.41	177

Source: Maryland Health Care Commission, October 2001

[7] Based on 70 or more discharges.
[8] The facility has a psychiatric daycare licensed for adolescents and adults, and is receiving increasing referrals from Anne Arundel County.
[9] Increased referrals are coming from area emergency rooms. Closure of Chestnut Lodge day treatment decreased support of outpatient rehabilitation for the gray-area population.
[10] Increased referrals are coming from area emergency rooms.
[11] Increased referrals from the Department of Juvenile Justice's Cheltenham facility have increased adolescent admissions.

Residential Treatment Centers

Maryland has 765 residential treatment center beds for children and adolescents throughout the State, as shown in Table 6-3.[12]

Table 6-3
Maryland Residential Treatment Centers: October 2001

Facility Name	Jurisdiction	Number of Beds
Edgemeade at Focus Point	Anne Arundel	26
Regional Institute for Children/Adolescents-Baltimore	Baltimore City	45
Woodbourne Center Inc.	Baltimore City	54
Good Shepherd Center	Baltimore City	105
Berkeley & Eleanor Mann Residential Treatment Center	Baltimore	17 (+ 17*)
Villa Maria	Baltimore	95
Chesapeake Youth Center	Dorchester	49
The Jefferson School	Frederick	50
Adventist Behavioral Health System of Maryland	Montgomery	83
Taylor Manor Residential Treatment Center	Howard	17
Regional Institute for Children/Adolescents-Rockville	Montgomery	80
Edgemeade at Upper Marlboro	Prince George's	61
Regional Institute for Children/Adolescents-Southern Maryland	Prince George's	40
Chesapeake Treatment Center at The Hickey School	Baltimore	26
Total		748 (765*)

Source: Maryland Health Care Commission Data; Office of Health Care Quality, DHMH Licensure Reports, October 2001
*17 RTC beds once operated at Rose Hill Center in Rockville were acquired by Sheppard Pratt, received CON approval in November 2001 for relocation to its Towson campus, and will be licensed at the Mann RTC in early 2002.

[12] In a one-day snapshot census, on October 15, 2000, 24 children and adolescents were receiving residential treatment in out-of-state facilities, according to the State Coordinating Council.

Only one RTC is dedicated to the care of children: Villa Maria in Baltimore County. The State's RTCs are further subdivided by the following types of population they serve:

- "Lisa L" population[13] – those children or adolescents at risk for over-staying in inpatient facilities, including hospitals and respite care;
- The "seriously emotionally disturbed delinquent youth" ("SEDDY") population – adjudicated by the court and committed to the Maryland Department of Juvenile Justice;
- Juvenile sex offender population – committed by the courts to the Maryland Department of Juvenile Justice with a principal offense of sex offender;
- General RTC population – not requiring a specialized program, either by court order or medical necessity.

The Commission has adopted a State Health Plan chapter that addresses the sex offender and "Lisa L" populations, at COMAR 10.24.07 F. and G., respectively[14].

Other special populations have been identified as needing separate and distinct RTC units and other resources to meet the needs of particular children and adolescents,[15] including children and adolescents with co-occurring disorders of mental illness and mental retardation, and adjudicated youth who require a higher level of care than that currently provided in the units for seriously emotionally disturbed delinquent youth ("SEDDY").

Respite Care

The respite level of care provides rehabilitation support and active treatment for children and adolescents.[16] Respite care for children and adolescents essentially means long-term psychiatric hospitalization, as opposed to the more usual connotation of a brief stay to spell other caregivers. There are five separate and distinct respite care units in three facilities in Maryland that serve children and adolescents; these are located at Sheppard Pratt Hospital in

[13] The so-called "Lisa L" case was a federal class action lawsuit brought in 1987 against the Maryland Department of Health and Mental Hygiene (DHMH), Department of Human Resources (DHR) and Department of Juvenile Justice, (formally the Department of Juvenile Services) (DJS), alleging that children and adolescents been held in Maryland's State psychiatric and private psychiatric hospitals after the time they are ready for discharge, as determined by the hospital treatment team, or had been discharged to placements in which they did not receive the services recommended by the hospital staff. An Interim Settlement Agreement, which required the State to implement discharge plans within decreasing timelines, went into effect in May 1990.

[14] The SHP permits an additional 12 RTC beds for the "Lisa L" population to be approved and implemented, if needed. The Subcabinet has requested that the Commission not consider proposals to implement these beds, until analysis of utilization data can determine if additional capacity is needed. The SHP at COMAR 10.24.07.07 identifies an additional 26 RTC beds as needed for treatment of adjudicated adolescent sex offenders, but the Commission has not scheduled a CON review for this bed capacity, pending further analysis and advice from DJJ.

[15] *Report of the Out-of-State Placement Workgroup: Resources for Maryland Youth in Out-of-State Institutional Placements*, Maryland Health Resources Planning Commission, March 20, 1998

[16] COMAR 10.21.27

Baltimore County, Brook Lane Psychiatric Center in Washington County, and Taylor Manor Hospital in Howard County. The Sheppard Pratt facility has two units, one each for children and adolescents, with a total of 26 beds. Brook Lane Psychiatric Center's unit is called Stonebridge, and serves youth between the ages of 11 and 14. Taylor Manor has two units, one providing a higher intensity of acre than the other. At any given time, over 60 youth are awaiting RTC placement in these respite care facilities. About half remain in respite care placements for more than 90 days. While the Commission does not regulate respite care, it is an integral part of the full continuum of care, and directly affects the availability of RTC and hospital services.

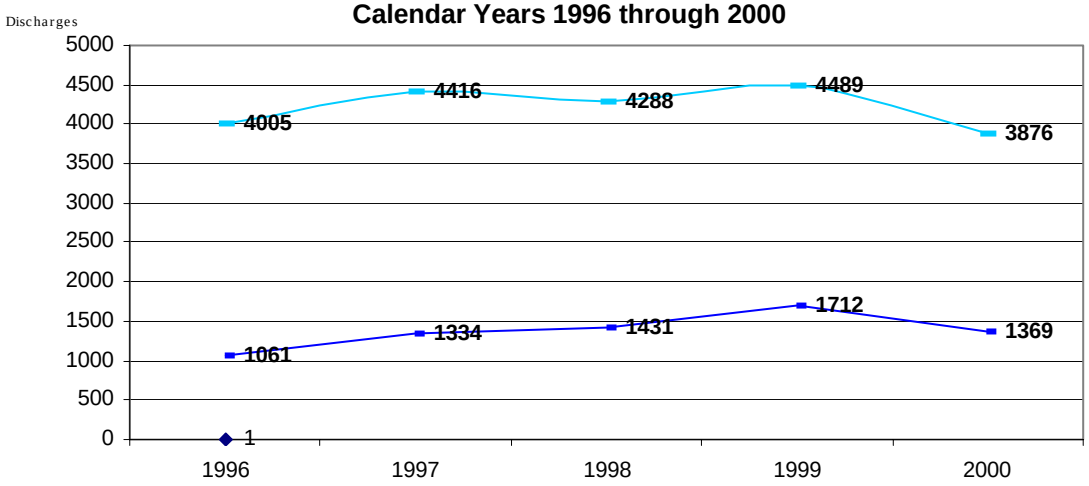
Trends in the Utilization of Hospital and Residential Treatment Center Services by Children and Adolescents

Figure 6-1 below illustrates the overall trends in inpatient admissions of children and adolescents, over all three hospital settings, acute general hospitals, private psychiatric hospitals, and State hospitals.

Figure 6-1

Child and Adolescent Inpatient Psychiatric Discharges All Hospital Settings

Calendar Years 1996 through 2000



Source: Maryland Health Care Commission, October 2001: Based on data from MHCC Hospital Discharge Abstract and data provided by the Mental Hygiene Administration.

Utilization Trends in Maryland Acute General Hospitals

In CY 1996, 527 children 11 years old or younger were discharged from general hospitals in Maryland. In CY 2000, there were 740 discharges for this age group, an increase of 40 percent. For the adolescents during this same time period, CY 1996 saw 1,414 discharges, and 1,557

discharges in CY 2000, an increase of 10 percent. During the same time period, however, the average length of stay for children decreased 28.7 percent, from 12.6 to 8.99 days, while the average length of stay for adolescents decreased by 16.1 percent, from 7.51 to 6.3 days. (See Appendix 6-1.)

Data provided in Appendix 6-1 also shows that Johns Hopkins Hospital, University of Maryland Hospital, and Franklin Square Hospital Center treated 95 percent of the children receiving inpatient services in CY 2000: 773 of the 813 discharges that year. A broader range of hospitals in the State treat adolescents; this includes the seven acute general hospitals with adult psychiatric services, identified in Table 6-2, that treat a substantial number of adolescents, but do not have designated adolescent units.

Utilization Trends in State Hospitals

The Mental Hygiene Administration, of the Department of Health and Mental Hygiene, operates two 18-bed adolescent units, one at Crownsville State Hospital in Anne Arundel County, and the other at the Finan Center in Allegany County.[17] Between CY 1996 and CY 1999, adolescent discharges from State psychiatric hospitals decreased by 22.47 percent, from 227 in CY 1996 to 176 in CY 2000. Patient days decreased significantly at these two facilities between 1996-2000, from 6,784 to 5,438, a decline of 19.8 percent. The average length of stay remained fairly stable over this time period, an average stay of 29.9 days in 1996, compared to 30.9 days in 2000.[18]

Utilization Trends in Private Psychiatric Hospitals

The number of child discharges from private psychiatric hospitals has increased 18.3 percent from CY 1996 to CY 2000 -- from 531 to 628. The number of adolescent discharges has decreased during this same period by 9.3 percent, from 2,364 to 2,143. The average length of stay for children in private psychiatric hospitals has decreased in the period CY 1996-CY 2000 from 16.63 to 14.58 days, a decrease of 12.3 percent. However, during this same period, adolescents discharged from private psychiatric hospitals showed a more significant decrease in average length of stay, from 24.31 to 8.61 days, a 64.6% decrease. Total charges for the combined age groups fell precipitously: from $44,624,874 to $19,889,109, a drop of $24,735,765 [in current dollars], or 55.4 percent, between CY 1996 and CY 2000.

The data presented in Table 6-4 below combines the experience of acute general and private psychiatric hospitals for the five calendar years examined, and provides separate child and adolescent utilization trends by age and year for discharges, patient days, total charges, average length of stay, average charge, and per diem, according to that breakdown. Between calendar years 1996 and 2000, the number of inpatient child psychiatric discharges has increased by 29%, from 1,058 to 1,368 discharges. Between 1996 and 2000,

[17] The State of Maryland does not operate a hospital-based facility for children ages 0-11; however, a few children are treated briefly at state hospitals. Between CY 1996 and CY 2000, no more than ten children, ages 0-11, were treated in State hospitals. Source: Mental Hygiene Administration, Data and Analysis Unit, October 16, 2001.

[18] Source: Mental Hygiene Administration, Data and Analysis Unit, October 16, 2001

discharges of adolescents from general and private psychiatric hospitals experienced a 2% decline, from 3,778 to 3,700; however, during the intervening years the number of adolescent discharges has fluctuated. The combined total of child and adolescent psychiatric inpatient discharges decreased during the period examined by 15 percent, from 5,957 to 5,080, but it is unclear whether the number of community-based services for children and adolescents has increased to a corresponding degree.

Table 6-4
Summary Data for Child and Adolescent Inpatient Psychiatric Discharges: All Hospital Settings, Calendar Years 1996 through 2000

HOSPITAL TYPE	AGES DESC.	TOTAL CASES	PATIENT DAYS	TOTAL(*) CHARGES	AVG. ALOS	AVG. (*) CHARGE	PER(*) DIEM
1996							
Total 0-11	0-11	1,061	15,487	$11,720,318	14.60	$11,078	$758
Total 12-17	12-17	4,005	74,856	$46,189,475	18.69	$12,226	$679
TOTAL	0-17	5,066	90,343	$57,909,793	17.83	$11,975	$693
1997							
Total 0-11	0-11	1,334	18,393	$13,260,417	13.78	$10,015	$730
Total 12-17	12-17	4,416	77,654	$40,350,270	17.58	$9,851	$566
TOTAL	0-17	5,750	96,047	$53,610,687	16.70	$9,891	$600
1998							
Total 0-11	0-11	1,431	18,345	$13,808,159	12.82	$9,704	$754
Total 12-17	12-17	4,288	53,939	$31,557,131	12.58	$8,018	$676
TOTAL	0-17	5,719	72,284	$45,365,290	12.64	$8,465	$698
1999							
Total 0-11	0-11	1712	22550	$20,907,194	13.17	$12,226	$927
Total 12-17	12-17	4489	49494	$39,958,750	11.03	$9,409	$807
TOTAL	0-17	6201	72044	$60,865,944	11.62	$10,218	$845
2000							
Total 0-11	0-11	1369	15816	$12,216,300	11.55	$8,930	$773
Total 12-17	12-17	3876	33702	$21,238,476	8.70	$5,740	$751
TOTAL	0-17	5245	49518	$33,454,776	9.44	$6,601	$759

Note: (*) Total charges, average charge, and per diem charges computed for general and private psychiatric hospitals only. INA – Information Not Available

Source: Maryland Health Care Commission, adapted from Maryland Hospital Discharge Abstract and Maryland Hospital Information System, October 2000

For children, the average length of stay has experienced a significant decrease from 14.62 days in CY 1996 to 11.56 days in CY 2000, or 21%. The average length of inpatient stay for adolescents decreased 57.6 percent between CY 1996 and CY 2000, from 18.02 to 7.64 days. The overall length of stay for the combined age groups dropped almost 50 percent from 17.28 to 8.70 days. Similarly, total charges for the combined age groups dropped from $57,909,793 to $33,454,776, a decrease of $24,000,000 [in current dollars], or 42 percent.

Utilization Trends in Residential Treatment Centers

A key to analyzing RTC issues is to understand that each of Maryland's 14 RTCs is a unique facility, with its own distinct combination of the variables that affect the utilization, financing, and management of all of Maryland's RTC facilities. These variable influences include:

- the populations served (age, sex, "Lisa L", seriously emotionally disturbed delinquent youth, violent juvenile sex offenders);
- geographic regions;
- the facility's corporate structure (i.e., non-profit, for profit, or State-operated);
- funding streams (i.e., Medicaid, State general funds, education funds, county jurisdictional funding, philanthropic funds);
- the entity controlling admissions (the court systems, Department of Juvenile Justice; the Multi-Agency Review Team; the State-contracted Administrative Service Organization, Maryland Health Partners);
- the facility's admission criteria; and
- the availability of appropriate community-based services.

With all of these variables continually in flux, different and conflicting trends emerge. Commission Staff contacted several RTCs in the State, inquired about their historic utilization and current trends, and learned that some RTCs are experiencing a significant number of empty beds for the first time in several years, while other RTCs are experiencing full occupancies with waiting lists, including in their respite programs.[19] Those facilities experiencing reduced utilization mention several factors influencing their current downward trend in occupancy. There have been marked decreases in the number of admissions from child serving agencies to these facilities. Part of the overall decrease may be due to direct instruction to the State-operated Residential Institutes for Children and Adolescents ("RICAs") from the State Mental Hygiene Administration to reduce lengths of stay to nine months. One RICA has taken this a step further, and is seeking to discharge patients as soon as they begin to improve, which often results in a reduced length of stay. In addition, some RICAs are not staffed to their license RTC capacity.

Some RTCs note that the new seclusion and restraint regulations adopted by the federal Centers for Medicare and Medicaid ("CMS")[20], formerly the Health Care

[19] Telephone contacts with RTCs by Commission Staff, October 11, 2001. The following discussion reflects the views of these providers.

[20] Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals under

Financing Administration, have added direct and indirect costs to the treatment of children and adolescents. Therefore, children and adolescents needing this type of care are either not admitted, or are discharged more quickly from the RTC to another type of facility. However, other RTCs have formulated inventive strategies to contend with the issues of staffing coverage, funding, and sharing of resources that result from the implementation of this rule.

Another factor cited by child mental health professionals in the declining utilization at some RTCs is the difficulty of obtaining the required documentation along with patient medical and educational evaluations from some local social services agencies, which often requires an inordinate amount of professional staff time, and is a pre-requisite to admission. Others contend that school districts in the state are responding to a financial disincentive to place children and adolescents into RTCs, thereby causing the downturn in admissions to some RTCs. Some school districts will not refer students to RTCs, because they have to bear the increased costs in education and therapy. The "inclusion" model adopted by these districts has, in fact, reduced the flow of referrals to RTCs.

Another factor affecting utilization of RTCs is the closure, or the potential closure, of some child and adolescent outpatient/day treatment programs. Without these community-based services, the condition of some children may deteriorate to the point that RTC placement or even inpatient admission becomes necessary. At least eight outpatient/day treatment sites for children and adolescents have closed due to lack of profitability in recent months. [21] The outpatient providers as well as some RTC administrators attribute their financial troubles to the decisions of the State's Administrative Service Organization-mandated reimbursement policies, citing failure to make timely payments (some RTCs are facing deficits of $2 million or more); retrospective utilization reviews that deduct funds from payments previously approved by the ASO; and a system that does not provide payment to an RTC until a patient has been a resident for at least six weeks. The RTC providers interviewed attribute much of their negative cash flow problems to these practices by the ASO.

The Commission is limited, in its ability to evaluate the impact of reimbursement and agency policies on the utilization of RTCs, and to determine if the appropriate number of such facilities is available to serve Maryland's children, by the continued lack of a reliable, readily available, and comprehensive database, which could collect and aggregate RTC information into one single source. This crucial information is not currently obtainable for the entire RTC population in Maryland.

Some organizations do maintain fragmented and partial data sets. For example, the Mental Hygiene Administration, in its management information system, does

Age 21; Final Rule 42CFR Parts 441 and 483, January 22, 2001

[21] These closures include VESTA, Prince George's County; Affiliated Sante, Charles County; Edgemeade, Charles County; Woodbourne, Baltimore City; Prince George's County Health Department; Granite House, part of the Sheppard Pratt Health System, at both St. Agnes Hospital in Baltimore City and Stoneridge in Randallstown, Baltimore County.

collect data for the Residential Institutes for Children and Adolescents in Rockville, Southern Maryland, and Baltimore. MHA also receives information on utilization from an *ad* hoc RTC Coalition. The Maryland Health Partners data collection system, known as the Crystal System, collects data based upon claims and authorizations. Since the State of Maryland contracts with Maryland Health Partners only to administer payment for Medicaid recipients who receive mental health treatment, these claims data do not reflect patient days not reimbursed by Medicaid. Specific information from Maryland Health Partners regarding RTC utilization is not readily available to public agencies, and has only recently become available to the Mental Hygiene Administration on a limited basis. The limited data produced by the Crystal System indicate that from July 1, 1997 through September 27, 2001 there were 2,152 discharges from all RTCs in Maryland. Of the 2,152 discharges:

- 15.1 percent (324) were for RTC stays of less than 90 days;
- 14.5 percent (313) were for stays from 91 to 180 days;
- 35.6 percent (766) were for stays from 181 to 365 days;
- 22.0 percent (433) were for stays from 366days to 1½ years; and
- 12.8 percent (276) of the discharges were for stays longer than 1 ½ years.

These data, while an interesting detail about Medical Assistance utilization at RTCs, are by definition not comprehensive—yet they represent the most complete data available on RTC use. The absence of a comprehensive, non-duplicated database with which to analyze RTC utilization across the State prevents the kind of definitive projection of bed need that the Commission issues for other facility-based health care services.

Utilization of Out-of-State RTC Providers

Maryland children and adolescents have historically received treatment in three out-of-state residential treatment centers: Devereux facilities in Florida and Georgia, and The Pines in Virginia. Twenty-seven Maryland children and adolescents were treated in these facilities during FY1999; this dropped to nineteen in FY 2000, and rose again to twenty-six in FY 2001. These figures represent significant progress in meeting a legislatively-mandated goal of minimizing the number of Maryland children sent out-of-state for RTC care.[22]

Factors Affecting the Utilization of Child and Adolescent Mental Health Services

- **Increased prevalence**

According to a 1999 report by the United States Surgeon General, 20 percent of U.S. children and adolescents (15 million), ages 9-17, have diagnosable psychiatric disorders. Further, the Center for Mental Health Services estimated that 9 to 13 percent of U.S. children and adolescents, ages 9 to 17, meet the definition of "serious emotional disturbance" and 5 to 9 percent of U.S. children and adolescents, "extreme

[22] Telephone contact with Jean Clarren, State Coordinating Council, Office of Children, Youth, and Families, Oct. 16, 2001.

functional impairment."[23] National data indicate that only about 20 percent of emotionally disturbed children and adolescents receive some kind of mental health services, and only a small fraction of them receive evaluation and treatment by child and adolescent psychiatrists.[24]

- **Impact of Managed Care**

With the "carving out" of mental health services from the Medicaid managed care system, and the creation of the Public Mental Health System in 1997,[25] it was anticipated that admissions of children and adolescents to inpatient psychiatric facilities would be restricted and lengths of stay would be curtailed. It was also anticipated that the Department of Health and Mental Hygiene's Mental Health Administration ("MHA") would receive a 1915c Medicaid Waiver that would encourage alternatives to inpatient care. However, as noted above, while inpatient hospital admissions of children and adolescents have decreased, length of stay in RTCs has increased since the public system began operation. Despite the increase in utilization and capacity of RTCs, there is anecdotal evidence that children and adolescents are not receiving the appropriate inpatient hospital services as evidenced by long stays in hospital emergency rooms before these individuals are either admitted, referred to another service, or retuned home.

- **Reimbursement Issues**

The public system's administrative organization, Maryland Health Partners, has strongly encouraged shorter lengths of stay in hospitals, resulting in reports of higher recidivism rates for mentally ill children and adolescents seeking inpatient placement at acute general inpatient hospitals. There, hospital administrators -- fearing the impact on their position relative to length-of-stay and cost targets imposed under the Health Services Cost Review Commission's rate-setting system – have begun to discourage admission of difficult cases, whose progress and length of stay is difficult to predict. In comments submitted on the working paper that formed the basis of Chapter 5 of this report, Michael J. Kaminsky, M.D., Clinical Director of the Johns Hopkins Department of Psychiatry and Behavioral Sciences, noted this phenomenon: "[a]ny psychiatric patient with a significant co-morbidity is diverted from general psychiatric units, typically to a state hospital or private hospitalization just because of an overt need for a longer length of stay . . . . From there, when their medical conditions require it, they are transferred back to the general hospital's medical units and so, ping-pong back and forth."[26] The reluctance to admit a difficult case is exacerbated for psychiatric patients with co-existing developmental disability. Commission staff worked during 2001 with HSCRC staff and representatives of the Mental Hygiene and Developmental Disabilities Administrations to encourage

[23] Department of Health and Human Services, *Report of the Surgeon General's Conference on Children's Mental Health: A National Agenda, December 1999*

[24] American Academy of Child and Adolescent Psychiatry Work Force Fact Sheet, at www.aacp.org/training/workforce.htm

[26] Michael J. Kaminsky, M.D., letter to Barbara G. McLean, [then] Interim Executive Director, Maryland Health Care Commission, August 13, 2001

the treatment of such patients, through a change in HSCRC's rate setting methodology that minimizes the financial disincentive to hospitals to admit them.

Financial problems also beset the private psychiatric hospitals, which projected losses of $7 million in 2001. To forestall the likelihood that any of the remaining private hospitals would close, the State of Maryland applied for and received a waiver from the federal Center for Medicaid and Medicare Services ("CMS") that will allow for a retroactive rate increase as of July 1, 2001, in the amount of $9 million in Medical Assistance funds for FY 2001. Private psychiatric hospitals will receive, on average, 84% of the HSCRC's approved rates for both commercially-insured and Medical Assistance patients.

- **Systemic Factors**

Developing a Consensus on RTC Bed Need

RTC beds provided for in the State Health Plan as potentially needed for the for "Lisa L" population (12 beds) and adjudicated juvenile sex offenders (26 beds) have not been reviewed or approved by the Commission for Certificate of Need, and no reviews for these beds are currently scheduled. The Commission raised the question with representatives of the agencies included in the Governor's Subcabinet for Children, Youth, and Families as to whether the original 24 (subsequently a total of 34, through bed creep at the two sites) as well as the additional "Lisa L" beds, in particular, were needed. These RTCs, as noted above, are restricted to admissions referred by a "Multi-Agency Review Team" comprised of representatives of these agencies.

In the fall of 2000, the Subcabinet convened a workgroup in response to these questions, and in compliance with a State Health Plan requirement[27] that it provide periodic reports to the Commission on the utilization of and continued need for the "Lisa L" beds. The workgroup also determined to examine the overall question of need for RTC bed capacity in the State. Along with the State's overall need for residential treatment center beds. The workgroup's recommendations included the following:

- that the 34 "Lisa L" beds currently in use be continued, based on regular full occupancy of the beds and a continued waiting list for the beds for an additional two years;
- that the beds continue to be considered temporary, as they are designated by the Plan, with a re-evaluation of the need for these beds at the end of the two-year period;
- that efforts continue to promote funding for use of community-based services for those children who can be served in placements that are less restrictive than the RTC level of care;
- that a decision about the use of the 12 additional beds be deferred until the larger, more complex issues [about bed need for the entire RTC-appropriate population] are addressed by the workgroup.[28]

[27] COMAR 10.24.07G.6(a).
[28] Recommendations to the Maryland Health Care Commission from the Subcabinet Regarding Residential Treatment Center Bed Need, December 12, 2000

Subsequent to the December 12, 2000 release of these recommendations, the Office of Children, Youth, and Families issued a report in response to an item in the 2001 Report of the Joint Budget Chairmen[29] that identified "serious problems" with basic data collection, in the provision of mental health services to children and adolescents who are the responsibility of one or more of the Subcabinet agencies. This report acknowledged that, because no comprehensive database on these children exists, several questions posed by State legislators about the number of children awaiting RTC placement, and the length of the wait for placement, could not be answered. However, the Subcabinet indicated that its member agencies have initiatives in process to address these types of important data requests. They include the reactivation and improvement of the "Lisa L" database; a Request for Proposal ("RFP") to conduct a statewide needs assessment of children and adolescent services, including RTCs, to be issued in the fall of 2001; and a proposal to develop two inter-related, human services database systems and a resource development directory, for which a contract is to be awarded November 1, 2001. The Subcabinet has committed to respond fully to the General Assembly's questions by January 2, 2003.

- **Lack of Coordinated Data Base for Planning Purposes**

This problem, discussed above, was recognized and discussed at length by the Subcabinet workgroup, which in July 2001 conducted a survey of the State child-serving agencies to determine the extent and adequacy of current agency data collection regarding RTC placements. The survey found that:

- Fragmentary and partial data are currently maintained separately by each child-serving state agency;
- Data are manually reported and aggregated, and not electronically stored;
- Data may be available from individual RTCs; however, the counts of children awaiting placement are not necessarily unduplicated, and the service status of the children is unknown.
- In addition, there is a lack of integration of databases among the involved state agencies. There is no formal interconnect or transfer of information from inpatient psychiatric hospitals to RTCs, to respite care, or to any community-based services. The lack of an up-to-date, integrated statewide database prevents the agencies that serve children from determining what children and adolescent psychiatric services are needed

- **Lack of Availability of Child and Adolescent Inpatient Care**

The closures of Gundry-Glass Hospital and Chestnut Lodge, two of the larger providers of child and adolescent inpatient psychiatric services in Maryland, leaves fewer options for child and adolescent psychiatric inpatient services, and has contributed – with other factors – to occasionally critical shortages of inpatient placements. As the *Baltimore* Sun

[29] Joint Chairmen's Report on Residential Treatment Center Bed Need, September 2001

reported in February 2000,[30] the number of children treated at Johns Hopkins Pediatric Emergency Department for behavioral or emotional problems has nearly doubled since 1995 to 730 a year. The University of Maryland Hospital's Pediatric Emergency department is also swamped, to the point where it has considered opening a walk-in clinic for children and adolescents with psychiatric problems.

[30]Diana K. Sugg, "A Hospital Crisis: Children in Need of Psychiatric Care," The Baltimore Sun, February 13, 2000

- **Lack of Specialty Programs in RTCs and Hospitals for any of the Following Populations: Mentally Ill/Developmentally Disabled; Seriously Emotionally Disturbed Children; Sex Offenders; Seriously Emotionally Disturbed Delinquent Youth**

Providers report that RTCs are serving a patient population with more severe conduct disorders, lower IQs, more chronic sex offenders, co-morbid conditions (mental illness, substance abuse, developmental disabilities and mental retardation, and other medical conditions), and more persistent mental illness. While there are some RTC providers who focus on some of these special populations – and indeed, State Health Plan sections to address two of them, the "Lisa L" and adjudicated sex offenders -- no separate continuum of care has been developed to treat youth with these more focused and intense special needs. For example, only one RTC in Maryland, Villa Maria in Baltimore County, treats seriously emotionally disturbed children ages 5 to 11. As noted above, Southern Maryland has no child psychiatric hospital resources; the Maryland counties in the Washington Metropolitan Area rely upon Children's National Medial Center in Washington, D.C. and Dominion Treatment Center in Virginia to provide inpatient child psychiatric services.

- **Maryland's Community Access Planning Process and *Olmstead vs. L.C.***

Well-established differences in approach to providing heath care services for children and adolescents in need of inpatient hospital or residential treatment services will be addressed in the context of Maryland's community access planning process, developed in response to the Supreme Court's *Olmstead* decision. With Governor Parris N. Glendening's July 26, 2000 Executive Order marking the tenth anniversary of the Americans with Disabilities Act, the State of Maryland became further engaged in a planning process to enhance the State's solid progress in efforts to serve persons with disabilities in well-integrated community-based settings. The Community Access Steering Committee was created to make recommendations to the Governor to enhance community-based services for individuals of all ages with disabilities, and, of course, to respond to *Olmstead v. L.C.,* 527 U.S. 581 (1999). This case addresses important questions regarding the obligations of individual states to meet the needs of persons with disabilities under Title II of the Americans with Disabilities Act ("ADA"). Olmstead is a landmark decision in the ongoing effort to allow all citizens to more fully participate in those programs that support community access and integration[31].

Government Oversight Of Inpatient Child And Adolescent Psychiatric And Residential Treatment Center Services

Government oversight of both inpatient child and adolescent psychiatric and RTC services in Maryland--including facilities, staff and program operation—is the responsibility of both federal and State

[31] Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, pages 9-11.

government entities. Although this working paper focuses on responsibilities of the Maryland Health Care Commission, it is also important to consider how child and adolescent inpatient psychiatric services and RTCs are regulated by other government agencies, particularly when considering a potential alternative to the current framework of Certificate of Need review.

Federal Agencies

Centers for Medicare and Medicaid Services ("CMS"). The Centers for Medicare and Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), within the United States Department of Health and Human Services ("DHHS") is the federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program ("SCHIP"). CMS provides health insurance for over 74 million Americans through Medicare, Medicaid, and SCHIP. In addition to providing health insurance, CMS also performs a number of quality-focused activities including regulation of laboratory testing, surveys and certification of health care facilities (including inpatient psychiatric hospitals and RTCs, and provides to beneficiaries, providers, researchers, and State surveyors information about these and other activities related to quality of care improvement.

Office of the Inspector General. The Office of the Inspector General ("OIG") within the federal DHHS is composed of the Office of Audit Services, Office of Investigations, the Office of Evaluation and Inspections, and the Counsel to the Office of Inspector General. The OIG works with CMS to develop and implement recommendations to correct systemic vulnerabilities detected during OIG/HHS investigations of care provided in health care facilities such as inpatient psychiatric facilities and RTCs.

State Agencies

Department of Health and Mental Hygiene. The Maryland Department of Health and Mental Hygiene ("DHMH") develops and oversees public health programs with the goal of protecting the health of Maryland residents. DHMH agencies with primary responsibility for regulating child and adolescent inpatient psychiatric services and residential treatment centers are the Mental Hygiene Administration, the Office of Health Care Quality (OHCQ), and the Maryland Medical Assistance Program. DHMH is a member of the Subcabinet for Children, Youth, and Families, and the Multi-Agency Review Team for "Lisa L" youth.

Mental Hygiene Administration. The Mental Hygiene Administration has as one of its responsibilities the oversight of the inpatient child and adolescent psychiatry and RTC services provided in State-funded facilities. This responsibility was significantly increased in 1997, when MHA assumed responsibility for Medical Assistance funds for mental health services, in the "carve out" that created the Public Mental Health System. In that year, mental health care for Medicaid recipients was "carved out" from the remaining array of Medicaid medical (and substance abuse) services, which were restructured, pursuant to Maryland's 1115 (c) Medicaid Waiver, into managed care organizations, or "MCOs." In Maryland, the program is known as HealthChoice. MHA assumed responsibility for the combined State-Only and Medical Assistance funding for mental

health services to Medicaid recipients and the resulting system also began to develop programs that included Medicaid recipients who were ineligible for the waiver MCOs, as well as the so-called "gray area" patients who, due to income, were deemed ineligible for Medicaid.

MHA, in collaboration with the county-level Core Services Agencies, manages the public mental health system, both its inpatient psychiatric segment (including inpatient child and adolescent services) and the system of community-based services. The Core Service Agencies are the local mental health authorities responsible for planning, managing and monitoring public mental health services at the local level. CSAs exist under the authority of the Secretary of the Department of Health and Mental Hygiene and also are agents of the county government, which must approve their organizational structure.[32] CSAs may develop comprehensive community-based plans to divert children and adolescents from hospital or RTC placement.

To carry out its responsibilities, MHA contracts with an administrative service organization ("ASO"); the current contractor is Maryland Health Partners, a subsidiary of Magellan Behavioral Health, Inc., which is responsible for determining eligibility and access to services, utilization review, the development of a management information system [the Crystal System], claims processing, and system evaluation. Both Medical Assistance and State general funds for the PMHS are part of the Mental Hygiene Administration budget. This includes funding for services offered by the PMHS such as outpatient clinics and psychiatric rehabilitation, as well as inpatient psychiatric hospitalization, residential treatment center placement, services rendered by individual practitioners, mental health-related Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") services, and laboratory services.

In FY 2001, the latest data available, the Maryland legislature appropriated a total of $637.5 million for MHA. Of this amount, $396.2 million ($310.4 million of Medicaid funding) was for community services, $235.9 million was for State-operated institutions, and $5.4 million was for program administration. Federal grants to MHA included a Federal Block Grant, Projects for Assistance in Transitioning from Homelessness ("PATH"), Shelter Care Plus, and other grants through the Center for Mental Health Services, which account for an additional $8.9 million in federal funding to Maryland citizens. Sixty-one percent of expenditures were for community services. Table 6-5 shows the number of children aged 17 and under with mental illness receiving public mental health services in FY 2000. The number of children and adolescents receiving inpatient or outpatient, community-based services increased from 7,500 in 1977 to 31,920 in 2001. The majority received services in the community, as a result of MHA's emphasis on prevention and early intervention.[33]

[32] Source: www.dhmh.state.md.us/mha/pmhs

[33] Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 18.

Table 6-5
Medicaid Recipients and Uninsured Aged 17 and Under With Mental Illness Receiving Services, by Age[34]: Maryland, Fiscal Year 2000

Children Ages 17 and Under			
Service Type	M.A. + Uninsured	Medicaid	Uninsured
Case Management	638	587	51
Crisis	48	45	3
Inpatient	2,302	2,295	7
Mobile Treatment	189	178	11
Outpatient	27,741	26,689	1,105
Partial Hospitalization	236	236	0
Psychiatric Rehabilitation	3,656	3,559	99
Residential Rehabilitation	26	26	0
Respite Care	24	24	0
Residential Treatment	937	932	6
Supported Employment	10	9	1
FY 2000 Subtotals	35,807	34,580	1,283

Source: Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p.20.

[34] Based **only** on Medicaid claims paid through March 31, 2001. These children and adolescents may have received more than one service; therefore, this is not an unduplicated count of children and adolescents served. (Source: Ibid., page 20)

Office of Health Care Quality. The Department's Office of Health Care Quality is mandated by State and federal law to determine compliance with the quality of care and life safety standards for a wide variety of health care facilities and related programs, including child and adolescent inpatient psychiatric services, whether free standing or as units in a general hospital. OHCQ issues the "special hospital" license to all private psychiatric and State hospitals, and, in the case of acute general hospitals, "deems" them to meet State licensure standards, by virtue of their accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). RTCs have a separate State licensure category. OHCQ's involvement in general hospitals is mainly limited to investigating complaints relating to quality of care issues from the general public, and complaints referred to it by the Maryland Insurance Administration.

Maryland Medical Assistance Program. As explained above, under the Maryland Medicaid program, child and adolescent inpatient psychiatric hospital services and RTC services for eligible Medicaid recipients are reimbursed through the "carve-out" of Medicaid funds administered by the Mental Hygiene Administration and its contracted administrative services organization, Maryland Health Partners.

Department of Public Safety and Department of Juvenile Justice. The criminal and juvenile justice programs spend a significant amount of funding on drug and alcohol programs serving the criminal justice population. Treatment programs serving this population operate inside institutions or incarceration and within communities. These programs are not reviewed by CON, but provide a substantial proportion of overall treatment capacity. It should be noted that older adolescents are sometimes adjudicated by the adult criminal justice system when their crimes are of such severity that their cases are transferred to the adult criminal justice system.

The Maryland Department of Juvenile Justice ("DJJ") provides individualized care and treatment to youth who have violated the law, or who are a danger to themselves or others. Through a variety of programs, DJJ works closely with other state agencies, including the Departments of Education, Human Resources, Health and Mental Hygiene, and local agencies to efficiently and effectively work with young people and their families reach their full potential as productive and positive members of society. According to the State Health Plan, at COMAR 10.24.07, DJJ controls admissions to adjudicated juvenile sex offender RTC beds and programs, subject to medical necessity criteria. Additionally, DJJ is responsible for providing mental health services to adjudicated youth within DJJ facilities and detention centers. DJJ is a member of the Subcabinet and a member of the MART.

Maryland State Department of Education. The Maryland State Department of Education ("MSDE") is charged with ensuring the right to a free and appropriate public education by implementing part B of the Individuals with Disabilities Education Act ("IDEA") for all educationally handicapped children from birth through the age of 20 years. It implements this charge within its Special Education Division, where services begin as soon as a child can benefit from them, regardless of age. COMAR 13A.09.10,

Educational Programs in Nonpublic Schools and Child Care and Treatment Facilities, is used to approve educational programs in facilities by state agencies and in facilities operating special education programs such as RTCs. The MSDE is responsible also for developing an Individualized Education Plan ("IEP"), a written description of goals and the means that the educational facility plans to use to help each student achieve these goals in the least restrictive environment. Representatives from local school systems participate on the local coordinating council and local management boards to plan for education services for the special education population. In an RTC, for Special Education students, the student to certified special education teacher ratio is 4 to 1; when the class size reaches 7 special education students, an educational aide is required. MSDE, too, is a member of the Subcabinet and a member of the MART.

Maryland Department of Human Resources. The Department of Human Resources ("DHR"), through its Social Services Administration, has the responsibility to determine eligibility for Medical Assistance, and to provide welfare services to children whose parents will not or cannot care for them. It also makes available a range of other services to children and families with special needs. These services include protective services to children, foster care, adoption, in-home aide services, day care, single parent services, respite care, intensive family services, services to families with children and family support centers. These services are provided primarily through the local departments of social services located in each of Maryland's 24 subdivisions. DHR is also a member of the Subcabinet, and of the Multi-Agency Review Team.

The Subcabinet/Office of Children, Youth, and Families. The Subcabinet for Children, Youth, and Families was created to promote interagency collaboration and increased partnership opportunities across the State in issues focused on children and their families. The Subcabinet provides leadership and policy direction and is comprised of the Secretaries of the Departments of Budget and Management, Health and Mental Hygiene, Human Resources, Juvenile Justice; the State Superintendent of Schools; the Special Secretary for Children, Youth, and Families; the Director of the Office for Individuals with Disabilities; and representatives from other State agencies as designated by the Governor. The Subcabinet Partnership Team addresses day-to-day operations and makes policy recommendations to the Subcabinet.
The Cabinet-level Governor's Office of Children, Youth, and Families ("OCYF") strives to provide support and assistance to help families nurture and care for their children. Established in May 1989 by Executive Order 01.01.1989.12, the Office for Children, Youth and Families believes that parents and local communities can best determine the strategies that will meet their children's needs. OCYF is a partner, facilitator, and collaborator with other State and local agencies, local management boards, and other community organizations. OCYF promotes child-centered, family-focused, and culturally-competent support to families.[35]

[35] www.ocyf.state.md.us

Initiatives under the leadership of the Special Secretary of OCYF include:

- Community Partnerships for Children and Families
- Governor's Council on Adolescent Pregnancy
- Governor's Commission on Infant Mortality Prevention
- Healthy Families Maryland
- Maryland School-Based Health Center Initiative
- State Coordinating Council for Residential Placement of Children with Disabilities
- Maryland Health Start Collaboration Office
- The Children's Trust Fund
- State Council on Child Abuse and Neglect

One of these initiatives, the Maryland State Coordinating Council ("SCC"), has specific relevance to child and adolescent inpatient psychiatric services and RTC services. To further monitor the State's long-standing concern for children who are placed in residential treatment, the SCC and the Local Coordinating Councils ("LCCs") were established during the 1980's as a strategy for bringing each agency's resources together for the benefit of Maryland's children needing residential placement. The SCC is the ongoing interagency collaboration responsible for ensuring that youth with disabilities are served in the most appropriate, least restrictive placement possible. Statutory language further detailing the SCC's authority and responsibility took effect in July 1987. In 1990, the SCC administratively moved to the Governor's Office for Children, Youth, and Families, and its enabling statute was incorporated in Article 49D. The guiding principles of the SCC/LCC are:

- to ensure that services are provided in a manner which most safeguards the rights of both parent and child;
- to utilize a structure that builds upon the strengths of existing procedures at the local level; and
- to provide an opportunity and incentive for resolution of interagency disputes at the lowest level possible.

The two primary goals for the SCC/LCC are[36]:

- to develop interagency plans for children to assure placement in the least restrictive environment appropriate; and
- to recommend to agencies the development of new and enhanced community-based programs to serve children with disabilities who might otherwise remain in restrictive placements that are distant (out-of-state or out-of-county) from their families and communities.

The members of the SCC include representatives from Maryland child-serving agencies: Department of Human Resources; Department of Health and Mental Hygiene; Department of Education; Department of Juvenile Justice; and the Office for Children, Youth, and Families and one nonvoting, *ex officio* representative of the Governor's Office for Individuals with Disabilities. By

[36] Ibid.

statute, members of the Local Coordinating Council, located in each county and Baltimore City, must include a representative from the Mental Hygiene Administration, the Developmental Disabilities Administration, and the local health department, the Department of Juvenile Justice the local Department of Social Services, the Division of Rehabilitation Services, the Core Service Agency, and the Local Management Board.[37] In addition, each LCC must have a parent advocate as a nonvoting member to support the parents of any child referred to services.

The SCC/LCC process has been in operation for almost 20 years (since 1982) in some jurisdictions, and has been fully operational since 1987 in all 24. Many individuals in local communities, therefore, are aware that this interagency resource is available. In addition, a representative of the Local Management Board is now a member of the LCC and through their participation they bring broad community concerns and commitment to ensuring this process is effective.

Office of the Attorney General, Health Education and Advocacy Unit (HEAU)

The 1998 General Assembly passed the Appeals and Grievance Law to provide patients with an enhanced ability to resolve disputes with their health insurance carriers regarding denial of coverage by carriers.[38]The process outlined in the Appeals and Grievance Law begins with an adverse decision issued to the patient by the carrier. An adverse decision is a written decision by a health insurance carrier that a proposed or delivered health care services are not medically necessary, appropriate, or efficient. After receiving an adverse decision, a patient may file a grievance through the carrier's internal grievance process. The Health Education and Advocacy Unit of the Office of the Attorney General is available to attempt to mediate the dispute, or if necessary, to help patients file grievances with carriers.[39]

Maryland Insurance Administration. The Maryland Insurance Administration ("MIA") provides for the licensure of insurers and agents; establishes financial and capital standards for insurers of all types, and sets requirements for rate making and disclosure, and for fair practices. The MIA handles consumer complaints regarding coverage decisions and appeals of medical necessity decisions made by HMOs or insurers. The Administration's Division of Life and Health is responsible for regulating life, health (including mental health care), HMO, annuity, and dental plan insurance lines.

In an effort to provide customer information in the area of health insurance, including services provided for child and adolescent inpatient psychiatric hospitalizations and RTC care, the Maryland Insurance Administration publishes a series of

[37] Local Management Boards ("LMBs") were established throughout the State of Maryland as the conduit for collaboration and coordination of child and family services, and work with local stakeholders to address the needs of and to set priorities for their communities.

[38] Annotated Code of Maryland, Insurance §15-10A-01 through §15-10A-09

[39] Office of the Attorney General, *Annual Report on the Health Insurance Carrier Appeals and Grievances Process, Health Education and Advocacy Unit*, Consumer Protection Division, November 2000

publications including the *Consumer's Guide to Health Insurance in Maryland,* a comprehensive guide to health care coverage.

Health Services Cost Review Commission. The Health Services Cost Review Commission ("HSCRC") is empowered by Health-General Article §19-216 to review and approve the rates and costs of hospitals in Maryland. Its jurisdiction includes non-federal acute general hospitals, non-governmental chronic hospitals, and private psychiatric hospitals. In addition to establishing a uniform accounting and reporting system, the HSCRC develops rate-setting policies and methodologies to carry out its functions. The HSCRC establishes room rates and other charges for hospitals that have licensed acute psychiatric beds. Historically, the HSCRC has not established separate and distinct room rates for child and adolescent inpatient psychiatric services in the acute general hospitals, as it does for the private psychiatric hospitals.

Maryland is the only state in the nation with a rate-setting system that functions as an alternative to the federal Medicare prospective payment system, as provided in Section 1814(b) of the Social Security Act. The federal government reimburses waivered facilities in Maryland for hospital services provided to Medicare patients on the basis of rates set by HSCRC, rather than by its own prospective payment system. The federal government also accepts the hospital rates set by HSCRC with regard to federal financial participation in the Maryland Medical Assistance Program (Maryland Medicaid) for hospital services. In this "all-payer" system, hospitals may not grant discounts to any other payers unless HSCRC has approved them; HSCRC has allowed only limited discounts for some insurers. Maryland's waiver test is based on a comparison of average rates of increase in Medicare Part A payments per admission between Maryland and the rest of the country as a whole. Good performance on the test will reflect improvements in controlling Medicare payments under the federal perspective payment system.

Maryland Health Care Commission. Through the health planning statute, the Maryland Health Care Commission ("MHCC") is responsible for the administration of the State Health Plan, which guides decision making under the Certificate of Need program and the formulation of key health care policies, and the administration of the Certificate of Need program, under which actions by certain health care facilities and services are subject to Commission review and approval.[40] Through the Certificate of Need program, the Commission regulates market entry and exit by the health care facilities and individual medical services covered by CON review requirements, as well as other actions the regulated providers may proposed, such as increases in bed or service

[40] The MHCC also establishes a comprehensive standard health benefit plan for small employers, and evaluates proposed mandated benefits for inclusion in the standard health benefit plan. In its annual evaluation of the small group market, the Commission considers the impact of any proposed new benefits on the mandated affordability cap of the small group market's benefit package, which is 12 percent of Maryland's average wage, and the impact of any premium increases on the small employers. Briefly, with regard to mental health and substance abuse, this is covered when delivered through a carriers' managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis and unlimited outpatient visits subject to the following cost sharing: in-network carrier pays 70%; out-of-network carrier pays 50%. Prescription drugs are covered with a $150 separate deductible for each covered person, and an open formulary with a three-tiered co-payment.

capacity, capital expenditures, or expansion into new service areas. The Commission has developed State Health Plan chapters in response to requests from the Subcabinet and other child serving agencies.

Entry into the market for proposed new inpatient child and adolescent facilities or bed capacity has been explicitly regulated through Certificate of Need since the 1988 enactment of a list of "medical services" subject to CON, if established by an otherwise-regulated health care facility[41]. As with all Certificate of Need review in Maryland, the analysis of applications for CON approval for new facilities or expanded bed capacity[42] evaluates how proposed projects meet the applicable standards and policies in the State Health Plan, and how they address the six general review criteria found in the Certificate of Need procedural regulations at COMAR 10.24.01.08G.[43] The State Health Plan currently in effect requires that a facility obtain a separate Certificate of Need for each division of inpatient psychiatry recognized by the SHP, i.e. a designated child, adolescent, or adult psychiatric service.

As noted in previous discussions in Phase I of this report concerning the effect of HB994 and its changes to Certificate of Need law applicable to "the closure of a hospital or part of a hospital," two of these 1999 statutory provisions significantly altered the Commission's oversight authority with regard to potential closures of hospitals or their inpatient psychiatry services, and with regard to the bed capacity of individual medical services.

The Certificate of Need procedural rules applicable to hospitals in jurisdictions with three or more hospitals at §19-120(l) explicitly include State hospitals, which also may close without action by the Commission, provided that the Commission has received written notification 45 days before the planned closure, and the hospital (or in this case, the Department of Health and Mental Hygiene, specifically, the Mental Hygiene Administration) has held a public informational hearing in the area affected by the closure. State statutes and regulation require that an RTC receive a Certificate of Need to close a facility. However, if a facility has been required to close as a result of an impending bankruptcy or violations of licensing or certification standards, which have resulted in a closure by the Office of Health Care Quality, the Commission has not required a CON review.

As noted in Chapter 5 of this report with respect to adult psychiatric beds and services, it is far less clear whether this comparatively quick and easy closure process also applies to the private

[41] Health-General §19-120(a).

[42] Bed increases in either service may be authorized by the commission without CON review through the statutory "waiver bed" rule that permits increases of 10 beds or 10% of total beds, which ever is less, two years after the last change in licensed bed capacity.

[43] In brief, these criteria require an application to: (1) address the State Health Plan standards applicable to the proposed project; (2) demonstrate need for the proposed new facility or service; (3) demonstrate that the project represents the most cost-effective alternative for meeting the identified need; (4) demonstrate the viability of the project by documenting both financial and non-financial resources sufficient to initiate and sustain the service; (5) demonstrate the applicant's compliance with the terms and conditions of any previous CONs; and (6) "provide information and analysis on the "impact of the proposed project on existing health care providers in the service area."

psychiatric hospitals, which are not classified as general hospitals under the licensure statute.[44] Interpretations of the provisions of HB994 related to acute general hospitals are based on their inter-connectedness: the bill ended the creation of waiver, or "creep" beds in general hospitals (this was clarified in the Commission's implementing regulations), in favor of the annual recalculation of licensed bed capacity "for a hospital classified as a general hospital,[45]" according to a factor of 140% of its previous year's average daily census. HB994 has not been interpreted as precluding the authorization of waiver beds for private psychiatric hospitals, and it has not been interpreted as permitting any but acute general hospitals (i.e., those subject to the annual application of 140% of last year's average daily census) to increase or decrease beds between members of merged asset systems.

Maryland's Certificate Of Need Regulation Of Inpatient Child And Adolescent Psychiatric And RTC Services Compared To Other States

Thirty-six states and the District of Columbia, as shown in the latest national directory published by the American Health Planning Association ("AHPA"), have Certificate of Need review for some number of health care facilities and proposed expansion of service capacity. Maryland is noted as one of twenty-six of those states that regulates psychiatric services.

In an effort to learn what other states are doing with regard to the regulation, by means of a Certificate of Need review program of either child or adolescent inpatient psychiatric services or residential treatment center services, Commission Staff contacted other states by means of electronic mail communication through an Internet forum established by the American Health Planning Association. Through this forum, staff received a total of eight (8) responses from Staff from other states' health planning units.

A representative from the State of Ohio responded that the state does not review either of these services through the CON program.[46]

Staff from the Central Virginia Health Planning Agency responded that Virginia is in the process of reviewing all services included in the State Medical Facilities Plan, including psychiatric services. Currently, in Virginia, all psychiatric service is grouped together for regulatory purpose, a situation that is problematic. There is no separate licensure or need methodology for child or adult services, or acute inpatient or residential treatment center services. Moreover, there are no adjustments for acuity, and others needing single, locked rooms, where the facility only has semi-private rooms. This creates lower occupancies and less efficient utilization of facilities.[47]

Staff from the State of Arkansas responded that Arkansas currently requires a CON for all psychiatric residential treatment facilities

[44] Health-General Article §19-307(a).
[45] Health-General Article §19-307.2(a)

[46] Electronic mail communication from Christine Kenney, Ohio Department of Health, September 21, 2001.
[47] Electronic mail communication from Karen L. Cameron, CHE, Executive Director/CEO, Central Virginia Health Planning Agency, Richmond, Virginia, September 21, 2001.

for children and youth. The formula that Arkansas uses is .385 beds per 1,000 persons age 6-17 and .300 beds per 1000 persons aged 18-21. Facilities requesting additional beds must have averaged a 90% occupancy rate for the previous calendar year. In order for a new facility to be approved for a given county, existing facilities in that county must have averaged an 80% occupancy rate for the previous calendar year.[48]

In Florida, the CON review process regulates licensed hospitals for children's mental health services, according to staff from the Florida Hospital Administration; however, not other types of residential treatment settings—although one type of licensed hospital bed for psychiatric services is called "intensive residential treatment facility". CONs are required in Florida in order to open specialty hospitals providing psychiatric services for children or adults through units in general hospitals. Florida also requires CONs for the expansion of bed capacity in either freestanding/specialty hospitals or units in general hospitals. Florida's regulations project need for children's mental health beds in two categories—psychiatric and substance abuse. The regulations use current use rates in each of 11 health planning districts applied to future population to predict gross bed need and then to adjust the need numbers based on occupancy at existing hospitals. In the most recent bed need projections, staff from the Florida Association reports, only one district was found to have a need for children's psychiatric beds (53 beds), and no districts were found to have any need for substance abuse beds (even though licensed beds exist in only 1 district).

According to Florida's most recent CON Annual Report, published by the Florida state health planning agency, CON activity for these types of beds has been very limited in the last ten years—with only 17 applications being filed during this period for child psychiatric services, and no applications being filed for children's substance abuse beds. When new beds have been approved, they have mostly been by means of conversion or transfer. Only 4 psychiatric beds, in the last five (5) years have been added through new construction; the Florida Hospital Administration staff did not know whether these were child or adult beds.

Possibly one explanation for this limited activity for these types of services in Florida is that when Florida first recognized children's psychiatric beds and substance abuse beds as distinct licensure categories in 1991, the state inventory listed 1,841 licensed beds as child psychiatric along with 259 as child substance abuse beds. Since 1992, this inventory has declined markedly, to 606 licensed beds for children's psychiatric services, with 15 licensed beds for children's substance abuse services.[49]

CON staff from the state of Missouri responded that the state does little to regulate inpatient child and adolescent psychiatric services by means of a Certificate of Need since it has have found

[48] Electronic mail communication from Mary Brizzi at the Arkansas Department of Health, September 21, 2001

[49] Electronic mail communication from Carol J. Gormley, Director of Governmental Relations, Florida Hospital Association, Tallahassee, Florida, September 21, 2001.

that the proposed service rarely goes over Missouri's $1,000,000 expenditure minimum for CON review.

The state of Michigan regulates child and adolescent inpatient psychiatric services with a need methodology, the base year of which, according to its regulations, Michigan's CON Commission may modify. It is also interesting to note that a requirement for approval of a CON for child and adolescent inpatient psychiatric beds is that the average occupancy rate for all licensed beds at the psychiatric hospital or unit shall be at 75% for the second 12 months of operation, and annually thereafter. The State of Michigan's definition of a "specialized psychiatric program" is very much like Maryland's residential treatment center. Projects involving either an increase in the number of beds (whether new, additional, replacement or converted) for a specialized psychiatric program for children or adolescents are subject to a comparative review.

As of October 1, 2002, Michigan will be eliminating CON regulation of partial hospitalization psychiatric programs. These programs are defined as follows:

> "a non-residential mental health treatment program in which clients are regularly scheduled to be treated for a minimum of six consecutive hours during any 24-hour period for a minimum of five (5) days per week; including psychiatric, psychological, social, occupational, therapeutic recreational elements, all of which are under psychiatric supervision; and provides services to clients who are diagnosed mentally or emotionally ill, and who are at risk of psychiatric inpatient hospitalization, or who might otherwise remain hospitalized on an inpatient basis in the absence of such a program.[50]"

Staff involved in CON review responded that South Carolina does not have separate bed need calculations or standards for inpatient child psychiatric beds. Any beds proposed must come from the general bed need, which the staff noted was currently negligible [with only two out of 14 service areas showing a need for psychiatric beds]. In South Carolina, adolescents can remain in an RTC up to age 21, whereas in Maryland it is up to the age of 18. South Carolina has CON standards and a bed need methodology projected by regional service area for RTCs. The standards note what minimum services should be available at a minimum. RTC beds for children and adolescents are distributed statewide, and are located within seventy-five (75) minutes travel time for the majority of residents of the state. South Carolina gives equal weight to the benefits of improved accessibility with the adverse affects of duplication in evaluating Certificate of Need applications for this service.[51]

Staff from the State of Kentucky responded that its State Health Plan provides that "no new psychiatric beds for children or adolescents shall be approved except for beds converted from existing acute care beds. No psychiatric beds for children or

[50] Electronic mail communication from Catherine Stevens, Michigan CON Commission, Michigan Department of Public Health, September 21, 2001.
[51] Electronic mail communication from Les Shelton, South Carolina Department of Health and Environmental Control, September 24, 2001.

adolescents focus on short-term (under 30 days) crisis stabilization." Kentucky also regulates psychiatric residential treatment facilities that are community-based, home-like eight bed facilities for ages six to 21[52].

[52] Electronic mail communication from Jayne M. Arnold, Kentucky Health Service, October 2, 2001.

Alternative Regulatory Strategies: An Examination Of Certificate Of Need Policy Options for Child And Adolescent Inpatient Psychiatric Services And RTC Services

The options discussed in this section represent alternative strategies governing oversight of inpatient child and adolescent psychiatric services and RTC services in Maryland. Each of these services is considered separately, with its potential alternative regulatory frameworks. All categories of inpatient psychiatric beds are regulated by the State Health Plan, whereas only the specialty RTC populations ("Lisa L" and adjudicated juvenile sex offenders) are addressed by individual sections of the State Health Plan at COMAR 10.24.07.07. The options below will apply differently to child and adolescent psychiatric hospitals as compared to RTCs.

Option 1: Maintain Existing Certificate of Need Review Program Regulation for Child and Adolescent Inpatient Psychiatric Beds and RTC Beds, With Commission-Mandated Data Collection for RTC Beds

This option would maintain the CON review requirement for new or expanded child and adolescent inpatient psychiatric and RTC services in current law and regulation, but with the addition of Commission-mandated data collection for RTC beds. Under current law, establishing a new inpatient child and adolescent psychiatric hospital requires a CON based on a state-projected need. The Commission's decision on a given application is based on its review of a proposed project's consistency with the State Health Plan's review standards and consensus with other stakeholders about need projection, along with the general CON review criteria. To exit from this market, the procedure varies according to the number of hospitals in the jurisdiction. In a jurisdiction with three or more hospitals, or for a State hospital, the facility must provide the Commission with written notification of the intended closure of the child and adolescent inpatient psychiatric hospital, and must hold an informational public hearing in the affected area. In jurisdictions with one or two hospitals, a public hearing must still be held, but action by the Commission through CON exemption is also required.

With regard to RTCs, only the "Lisa L" and violent juvenile sex offender populations are addressed in the SHP. Those wishing to develop an RTC serving other specialized populations or a generic RTC could have to petition the Commission to develop a State Health Plan section with applicable standards, or could apply for CON approval and be reviewed according to the general CON review criteria at COMAR 10.24.01.08G. The regulations establish the principle that the "burden of proof" of need for the new facility or bed capacity rests with the applicant.

This option also proposes to address the Commission's long standing need for specific data that measures utilization of RTCs in relation to the capacity of the system, that monitors the system to project short and long term system trends, none of which can be accomplished through existing data systems. Active involvement in RTC data collection, which could be initiated under the Commission's existing data collection authority, would require additional staff resources, and represent an extension of the Commission's current involvement in this health care sector.

Option 2: Expand Certificate of Need Program Regulation

As noted above, the closure of an inpatient psychiatric service requires either a 45-day notice or an exemption from CON review, depending upon the number of hospitals in the jurisdiction. The closure of a State hospital or part of a State hospital requires only the 45-day notification, regardless of the jurisdiction. Restoring the statutory requirement for some level of action by the Commission in all proposed closures of inpatient psychiatric services in acute general hospitals is a second alternative regulatory strategy. A finding by the Commission that exempts a proposed hospital service closure from CON review is currently needed in jurisdictions with one or two hospitals; only notice to the Commission and a public hearing is necessary for service closure in a multiple hospital jurisdiction. Option 2 would strengthen current oversight of inpatient psychiatric service closures by requiring hospitals in multiple hospital jurisdictions to obtain an exemption to exit the market.

This option supports placing greater public policy emphasis on insuring geographic access to inpatient psychiatric services (including child and adolescent psychiatric services). This option does not apply to RTCs.

The recent hospital closures at Gundry-Glass Hospital and Chestnut Lodge may well have affected future access to care for mentally ill children and adolescents. Current statute allows hospitals in multiple hospital jurisdictions, including Baltimore City and Montgomery County, where these two hospitals were located, to close without Commission oversight or action, after notification and a public hearing. Requiring the same level of review for multiple hospital jurisdictions as now exists in one- or two-hospital jurisdictions would allow public review and community input into the potential impacts and solutions of the closure of a child and adolescent psychiatry service in all areas of the State.

Expansion of regulation regarding RTCs would first require the expansion of the existing State Health Plan chapter to include standards and need projections for all RTCs. This expansion could also include respite care, since -- as it is presently constituted -- has become a placement characterized by much longer stays and services that mirror those in an extended-stay hospital setting. This expanded regulatory scope would require the development of new databases to make informed planning decisions.

Option 3: Partially Deregulate Child and Adolescent Inpatient Psychiatric Services and RTC Services

A partial deregulation of these services from Certificate of Need review could involve one or the other of the two services. The Commission could decide to retain CON review for inpatient services to children and adolescents, and defer in matters affecting RTC bed capacity to the Subcabinet for Children, Youth, and Families, since the Subcabinet agencies are so intensively engaged in providing services directly, and in bearing the cost of those services. The Commission already actively engages the Subcabinet and its individual agencies in CON reviews for RTCs and child/adolescent hospital facilities. Any decisions about health care services to the children and

adolescents for which the component agencies bear responsibility and cost have a direct impact on planning, budgeting, and legislation relating to all children and adolescents in the State, responsibilities which rest with the Subcabinet. This option could lead to better coordination of services because the same entity would be responsible for the planning for RTCs and community-based services for this population. Retaining Certificate of Need review for inpatient beds and services may still make sense, even under this scenario, because to remove some acute and special hospital beds from the dual authority of MHCC and HSCRC would fragment a unified and successful regulatory framework, and potentially destabilize an already challenged health care sector.

Taking the opposite perspective, the Commission could consider incorporating the approach proposed by Chapter 5's option, of removing the requirement for separate CON approval for a facility with an existing adult inpatient psychiatric program to add either a child or adolescent service. With the requisite changes to the State Health Plan, to help ensure the appropriate clinical and programmatic capabilities, this expansion of existing services could be accomplished through a less intensive level of review, such as CON exemption. It would have the advantage of enabling experienced providers of inpatient psychiatric care for adults to expand access to child and adolescent services, after an expedited review.

This option would, however, maintain regulation of RTC services by the Commission. The Commission has the knowledge, experience, and expertise to plan for the entire system of child and adolescent inpatient care. No other governmental entity in the State has the statutory mandate to plan for both the public, private, and non-profit sectors of the health care system. The Commission is, and continues to be, situated where it can act as an arbiter among the child-serving agencies, providers, advocates and other stakeholders because its constituency comprises the entire State.

Option 4: Deregulation of Inpatient Child and Adolescent Psychiatric Facilities from CON Review With Responsibility for Monitoring Transferred to the Mental Hygiene Administration, the Subcabinet, or the Office for Children, Youth, and Families

As noted above, MHA is responsible for administering the Public Mental Health System as well as General Assembly-appropriated funds that support inpatient and outpatient programs. Given these planning and financial responsibilities, it would logical to assign responsibility for the monitoring of need to the agency statutorily accountable to the legislature for the majority of the funding of child and adolescent psychiatric facilities. MHA plans for services, collects data, and assures that quality mental health care is available for the citizens of Maryland, including children and adolescents.

A similar rationale for the deregulation of child and adolescent psychiatric facilities and deferring to MHA would apply to either the Subcabinet or the Office for Children, Youth, and Families. Since the Subcabinet is comprised of representatives of all of the child-serving agencies plus representatives of the Department of Budget and the Office

of the Attorney General, this agency would also have the expertise and experience to monitor planning for these services. Likewise, the Office for Children, Youth, and Families would have similar capabilities.

Option 5: Deregulate Child and Adolescent Psychiatric Services from Certificate of Need Review; Create Data Reporting Model to Encourage Quality of Care

Another option for the regulation of psychiatric services for children and adolescents – similar that proposed for many of the other Certificate of Need-regulated services examined in this two-year study -- involves replacing the CON program's requirements governing market entry and exit with a program of mandatory data collection and reporting, to encourage continuous quality improvement through the gathering and periodic publication of comparative information about existing programs. Performance reports, or "report cards" are intended to incorporate information about quality decisions made by both employers and employees in their choice of health plans, and by consumers whose health plans permit a measure of choice in providers. Performance reports can also serve as benchmarks against which providers can measure themselves, and seek to improve quality in any areas found deficient. As such, report cards may both inform consumer choice and improve the performance of health services, and could either take the form of public report cards, designed for consumers, or performance reports designed to provide outcomes information and best-practices models for providers.

Option 6: Deregulation of Child and Adolescent Inpatient Psychiatric Services and Residential Treatment Centers from Certificate of Need Review

Under this option, all CON review related to both market entry and exit would be eliminated for child and adolescent inpatient psychiatric services and residential treatment centers in Maryland. Repeal of CON has been associated with increases in supply of services in several states, but the effect of removing any constraint on market entry (or exit) would be different for each service, depending on the role played by the present framework's constraints on reimbursement and length of stay constraints in the sector's stability and cost-effectiveness. It is unlikely, for example, that complete deregulation from CON review would result in a significant increase in the supply of child and adolescent hospital beds, because of the continued restrictions on inpatient admission and length of stay by managed care. However, the same level of constraint may not be operating with respect to RTC utilization, and without the pre-requisite of demonstrating need, the supply of RTC beds may increase. Another factor in any consideration of removing the CON requirement for an expansion of child and adolescent psychiatric hospital services or residential treatment centers is the increased pressure of any expansion on the critical shortage of nurses and other professional staff.

In the absence of CON regulation by the Commission, governmental oversight would

come from existing agencies such as the Office of Health Care Quality, the Mental Hygiene Administration, and the Medicaid program.

Table 6-6
Summary of Regulatory Options:
Child and Adolescent Psychiatric Services

Options	Level of Government Oversight	Description	Administrative Tool
Option 1: Maintain Existing CON Regulation	No Change in Government Oversight	• Market Entry Regulated by CON/Exemption (for merged systems) • Market Exit Through Notice or Exemption	Commission Decision (Certificate of Need/Exemption/Notice)
Option 2: Expand CON Regulation	Increase Government Oversight	• Market Entry Regulated by CON • Market Exit Through Exemption	Commission Decision (Certificate of Need/ Exemption)
Option 3: Partially Deregulate Child & Adolescent Inpatient Psychiatric Services and RTCs	Partial Change in Government Oversight	• Market Entry and Exit Changed for One or the Other of the Services	Commission Decision (Certificate of Need/ Exemption/Notice)
Option 4: Deregulate C/A Psychiatric Facilities from CON; Monitoring by MHA, the Subcabinet, or Office of Children, Youth, and Families	Change Government Oversight	• No barrier to Market Entry; Decision by Funding Agency to Approve and Reimburse New Bed Capacity or Facilities	Indicated Agency Reviews and Approves proposed new Capacity
Option 5: Deregulate C/A Inpatient Psychiatric Services, Create Data Reporting Model	Change Government Oversight	• No Barrier to Market Entry or Exit	Performance Reports/ Report Cards
Option 6: Deregulate C/A Inpatient Psychiatric Services and RTCs from CON Review	Change Government Oversight	• No Barrier to Market Entry or Exit	Remaining Agencies Exercise Oversight Authority (OHCQ, MHA, Medicaid)

Commission Recommendations

Recommendation 6.0

The Commission should continue its regulatory over-sight of child and adolescent inpatient psychiatric and resi-dential treatment center ("RTC") services through the Certificate of Need review process.

Recommendation 6.1

The Commission should modify the State Health Plan's current requirement for a separate Certificate of Need for each additional category of inpatient psychiatric service, to require an exemption from CON, based on clinical and program standards for the proposed new service to be established in the State Health Plan for each category of inpatient psychiatric service. This change is particularly important to expanding access to inpatient psychiatric beds dedicated to the care and children and adolescents, many of which have been closed by private psychiatric facilities over the past decade.

Recommendation 6.2

The Commission should support efforts to establish an on-going comprehensive data system and bed registry for RTCs. The Commission, in partnership with the Governor's Office of Children, Youth, and Families and the Mental Hygiene Administration, should make recommendations to conduct a study on the scope, content, and ongoing administration of this database.

The Commission recommends that Maryland continue to regulate the establishment of inpatient psychiatric beds and facilities for children and adolescents, and residential treatment centers for this population, by means of the Certificate of Need process, and, proposes to develop certain changes and clarifications to its current regulatory authority, in the State Health Plan, to implement Recommendations 6.1, as discussed under a similar recommendation in Chapter 5.

This change to the existing State Health Plan for inpatient psychiatric services would remove the requirement that a hospital with an existing inpatient service obtain an additional separate CON approval for each category of psychiatric care. Staff will develop specific State Health Plan standards to guide the review and approval of proposed additional service, possibly through a CON exemption review. These standards will be included in an update and revision of the Plan, and thereby receive extensive additional public comments as part of the regulatory review process. They would include consideration of requirements for Board Eligible/Board Certified specialists in the service to be added, specialized staffing, and separate clinical space and programs.

In order to inform and support effective planning and sound CON decisions for RTC services, it is critical that a comprehensive data bank and bed registry be developed and maintained. To realize the development of such a data system will require the commitment of sufficient resources and agreements among key stakeholders on the appropriate roles of each agency. The Commission will work closely with the other responsible State agencies toward the

development of the data needed to make the best use of available funding.

APPENDIX 6-1

Inpatient Psychiatric Discharges, Acute General and Private Psychiatric Hospitals by Age Category
Calendar Years 1996 to 2000

Appendix 6-1
Inpatient Psychiatric Discharges, Acute General and Private Psychiatric Hospitals by Age Category
Calendar Years 1996 to 2000

COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
ALLEGANY	MEMORIAL CUMBERLAND	0-12 Years	2	1	0	1	3
		13-17 Years	3	1	2	0	2
		18 above	31	27	13	20	12
	SACRED HEART	0-12 Years	0	0	0	0	1
		13-17 Years	23	27	26	22	41
		18 above	536	487	598	672	657
FREDERICK	FREDERICK MEMORIAL	0-12 Years	0	1	2	1	0
		13-17 Years	3	1	4	1	1
		18 above	530	556	567	589	553
GARRETT	GARRETT COUNTY	0-12 Years	0	0	1	0	0
		13-17 Years	0	1	0	0	1
		18 above	22	14	11	22	14
WASHINGTON	WASHINGTON COUNTY	0-12 Years	1	1	0	1	2
		13-17 Years	16	19	22	9	20
		18 above	645	636	606	568	648
	WESTERN MARYLAND TOTAL		1,812	1,772	1,852	1,906	1,955
MONTGOMERY	HOLY CROSS	0-12 Years	0	0	0	1	0
		13-17 Years	6	1	5	2	1
		18 above	209	174	179	81	31
	MONTGOMERY GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	86	80	57	64	91
		18 above	873	852	912	916	991
	SHADY GROVE ADVENTIST	0-12 Years	1	0	2	2	4
		13-17 Years	2	0	2	2	2
		18 above	13	19	31	19	28
	SUBURBAN	0-12 Years	0	1	0	0	1
		13-17 Years	48	53	47	61	76
		18 above	671	567	588	706	789
	WASHINGTON ADVENTIST	0-12 Years	0	2	2	0	0
		13-17 Years	102	100	99	95	113
		18 above	1,338	1,389	1,414	1,480	1,453
	MONTGOMERY COUNTY TOTAL		3,349	3,238	3,338	3,429	3,580

COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
CALVERT	CALVERT MEMORIAL	0-12 Years	0	0	1	0	1
		13-17 Years	146	152	138	121	110
		18 above	340	263	324	318	355
CHARLES	CIVISTA MEDICAL	0-12 Years	0	1	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	6	5	11	12	6
PRINCE GEORGE'S	DOCTORS HOSPITAL	0-12 Years	0	1	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	11	9	5	12	13
	FORT WASHINGTON	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	0	5	0	2	5
	LAUREL REGIONAL	0-12 Years	0	0	0	0	0
		13-17 Years	8	12	8	12	8
		18 above	601	509	553	510	641
	PRINCE GEORGE'S HOSPITAL	0-12 Years	1	0	1	0	0
		13-17 Years	79	54	45	21	34
		18 above	929	754	1,000	1,040	1,244
	SOUTHERN MARYLAND	0-12 Years	0	0	0	0	2
		13-17 Years	65	73	119	104	103
		18 above	701	769	785	704	811
ST. MARY'S	ST. MARY'S	0-12 Years	1	0	0	0	0
		13-17 Years	2	4	3	5	3
		18 above	396	374	337	345	328
	SOUTHERN MARYLAND TOTAL		3,286	2,985	3,330	3,206	3,664
ANNE ARUNDEL	ANNE ARUNDEL MEDICAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	1	0	2	0
		18 above	28	15	24	13	30
	NORTH ARUNDEL	0-12 Years	1	1	0	1	0
		13-17 Years	1	0	1	0	0
		18 above	634	626	571	604	689
BALTIMORE COUNTY	FRANKLIN SQUARE	0-12 Years	17	136	182	173	211
		13-17 Years	13	26	28	4	4
		18 above	750	820	904	728	954
	GBMC	0-12 Years	0	0	0	1	1
		13-17 Years	1	1	1	0	4
		18 above	35	41	39	56	82

NORTHWEST HOSPITAL	0-12 Years	0	0	0	0	0
	13-17 Years	0	1	0	0	1
	18 above	32	31	22	25	22
ST. JOSEPH	0-12 Years	2	9	5	6	9
	13-17 Years	8	55	69	88	86
	18 above	376	465	464	517	483

COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
BALTIMORE CITY	BON SECOURS	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	1
		18 above	16	20	9	447	1,768
	CHILDREN'S HOSPITAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	0	0	1	0	0
	CHURCH HOSPITAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	14	13	11	8	0
	GOOD SAMARITAN	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	35	35	26	20	25
	HARBOR HOSPITAL	0-12 Years	0	3	0	1	0
		13-17 Years	0	0	0	0	0
		18 above	16	12	13	18	18
	JAMES L. KERNAN	0-12 Years	5	2	3	1	4
		13-17 Years	68	59	60	53	95
		18 above	0	1	0	0	0
	JOHNS HOPKINS	0-12 Years	315	231	269	237	262
		13-17 Years	250	212	193	208	233
		18 above	1,447	1,563	1,539	1,918	1,890
	JOHNS HOPKINS BAYVIEW	0-12 Years	0	0	1	0	0
		13-17 Years	25	24	24	12	20
		18 above	744	684	697	724	820
	JOHNS HOPKINS ONCOLOGY	0-12 Years	0	0	0	0	0
		13-17 Years	1	0	0	0	0
		18 above	3	0	0	2	2
	LIBERTY MEDICAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	1	0	0
		18 above	2,270	1,995	2,143	1,039	0
	MARYLAND GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	13	0	0	1	1
		18 above	929	770	725	825	1,030
	MERCY	0-12 Years	2	2	0	0	0
		13-17 Years	39	14	9	0	0
		18 above	125	81	37	18	23

SINAI	**0-12 Years**	0	0	3	1	2
	13-17 Years	4	14	27	22	17
	18 above	800	1,036	1,132	1,231	1,274
ST. AGNES	**0-12 Years**	2	1	2	0	1
	13-17 Years	2	0	3	1	0
	18 above	40	24	34	35	34
UNION MEMORIAL	**0-12 Years**	1	0	1	0	1
	13-17 Years	1	1	2	3	1
	18 above	903	824	879	952	1,094

COUNTY	*HOSPITAL PROVIDER*	*AGE*	*DISCHARGES*				
			1996	*1997*	*1998*	*1999*	*2000*
	UNIVERSITY OF MARYLAND	0-12 Years	179	260	293	340	300
		13-17 Years	12	24	20	12	14
		18 above	1,540	1,471	1,413	1,384	1,340
CARROLL	CARROLL COUNTY GENERAL	0-12 Years	0	2	18	7	6
		13-17 Years	59	73	110	101	127
		18 above	703	619	687	688	666
HARFORD	FALLSTON GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	1
		18 above	18	19	17	35	44
	HARFORD MEMORIAL	0-12 Years	0	0	0	1	0
		13-17 Years	24	25	35	28	24
		18 above	541	417	501	524	443
HOWARD	HOWARD COUNTY	0-12 Years	5	2	3	1	4
		13-17 Years	68	59	60	53	95
		18 above	542	457	413	459	466
	CENTRAL MARLAND TOTAL		17,651	17,271	17,720	17,626	18,722
CECIL	UNION HOSPITRAL	0-12 Years	0	0	0	0	0
		13-17 Years	1	0	1	0	1
		18 above	535	475	402	392	381
DORCHESTER	DORCHESTER GENERAL	0-12 Years	11	2	1	0	0
		13-17 Years	146	76	44	87	104
		18 above	310	387	327	446	526
KENT	KENT AND QUEEN ANNE'S	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	1	0	0
		18 above	18	8	2	12	14
SOMERSET	EDWARD W. MC CREADY	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	0	14	4	5	7
TALBOT	MEMORIAL AT EASTON	0-12 Years	2	1	0	3	2
		13-17 Years	2	0	3	2	0
		18 above	171	24	15	22	28
WICOMICO	PRMC	0-12 Years	1	0	1	1	0
		13-17 Years	3	3	1	5	1
		18 above	429	408	402	476	518
WORCESTER	ATLANTIC GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	1
		18 above	4	3	5	6	5

	EASTERN SHORE TOTAL		1,633	1,401	1,209	1,457	1,588
		0-12 Years	544	657	788	778	813
		13-17 Years	1,262	1,187	1,210	1,148	1,342
		18 above	21,860	20,767	21,392	21,645	23,255
	MARYLAND TOTAL		23,666	22,611	23,390	23,571	25,410